

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

PERSONALCARE SERVICES/COST REPORT
Exemption Form

Due Date: JULY 28, 2006

PLEASE COMPLETE AND SUBMIT TO THE DMA ANALYST NOTED BELOW

(Agency Name)

(Agency Address)

(Agency's Fax #)

(Agency Phone #)

(Medicaid Provider # (s))

This agency is requesting exemption for the submission of the 2004 Cost Report for the following reason(s):

- ☐ The agency made less than \$50,000 during the reporting period
- ☐ The agency was operative six months or less
- ☐ Other-

(Signature of the Provider Agency)

DATE

(Printed name of person signing above)

Exemption from the 2005 Personal Care Services Cost Report requirement is/is not granted.

Signature of the DMA Analyst

Date

Mailing Address (for regular mail):
DHHS-DMA-Finance Management
1985 Umstead Drive, Raleigh, NC 27603

Fax # - 919-715-2209
Office # 919-855-4200